

**Affected Programs:** BadgerCare Plus, Medicaid

**To:** Substance Abuse Day Treatment Providers, HMOs and Other Managed Care Programs

## Changes to Prior Authorization for Substance Abuse Day Treatment Services

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for substance abuse day treatment services, effective October 2008, with the implementation of the ForwardHealth interChange system. These changes include the following:

- Establishing deadlines for providers to respond to returned PA requests and PA amendment requests.
- Revising all PA forms. The following PA forms will be available to download and print from the Web at [dhfs.wisconsin.gov/ForwardHealth/](http://dhfs.wisconsin.gov/ForwardHealth/):
  - ✓ Prior Authorization Request Form (PA/RF), F-11018 (10/08).
  - ✓ Prior Authorization Amendment Request, F-11042 (10/08).
  - ✓ Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), F-11037 (10/08).

Providers may also order copies from Provider Services.

The changes were made to do the following:

- Provide efficiencies for both providers and ForwardHealth.
- Accommodate changes required for full National Provider Identifier implementation.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

A separate *Update* will give providers a calendar of additional important dates related to implementation including when to begin submitting the revised PA forms.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

### Changes to Prior Authorization with the Implementation of ForwardHealth interChange

In October 2008, the Department of Health and Family Services (DHFS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA forms and procedures that are detailed in this *Update*. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements). The changes were made to:

- Provide efficiencies for both providers and ForwardHealth. Providers will be able to submit PA

requests and receive decisions and requests for additional information via the ForwardHealth Portal.

- Accommodate changes required for full National Provider Identifier (NPI) implementation. Prior authorization forms were revised to include elements for providers to indicate NPI and taxonomy information.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

*Note:* Specific implementation dates will be published in a separate *Update*. Use of information presented in this *Update* prior to implementation may result in returned PA requests.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

## Submitting Prior Authorization Requests

Using the ForwardHealth Portal, providers will be able to submit PA requests for *all* services requiring PA. In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

## Prior Authorization Numbers

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was

received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 1 of this *Update* for information about interpreting PA numbers.

## Changes to Prior Authorization Forms

With the implementation of ForwardHealth interChange, substance abuse day treatment service providers submitting a paper PA request will be required to use the revised PA/RF. Refer to Attachments 2 and 3 for completion instructions and a copy of the PA/RF for providers to photocopy. Attachment 4 is a sample PA/RF for substance abuse day treatment services.

*Note:* If ForwardHealth receives a PA request on a previous version of the PA/RF, a letter will be sent to the provider stating that the provider is required to submit a new PA request using the proper forms. This may result in a later grant date if the PA request is approved.

## Revisions to the Prior Authorization Request Form and Instructions

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).
- Checkboxes are added for HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- The term “rendering provider” replaces “performing provider” to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider’s name and address fields, providers are now required to include the ZIP+4 code (Element 4) to accommodate NPI implementation.

## Prior Authorization Attachments

With the implementation of ForwardHealth interChange, substance abuse day treatment service providers submitting a paper PA request will be required to use the revised Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), F-11037 (10/08). While the basic information requested on the form has not changed, the format of the form has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Refer to Attachment 7 for a copy of the completion instructions for the PA/SADTA. Attachment 8 is a copy of the PA/SADTA for providers to photocopy.

## Obtaining Prior Authorization Request Forms and Attachments

The PA/RF and PA/SADTA are available in fillable PDF or fillable Microsoft® Word from the Forms page at [dhfs.wisconsin.gov/ForwardHealth/](http://dhfs.wisconsin.gov/ForwardHealth/) prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically. To use the fillable PDF, click on the dash-outlined boxes and enter the information. Press the “Tab” key to move from one box to the next.

To request a paper copy of the PA/RF or PA/SADTA for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the form (if applicable) and mail the request to the following address:

ForwardHealth  
Form Reorder  
6406 Bridge Rd  
Madison WI 53784-0003

## Prior Authorization Decisions

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved as requested.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

## Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider’s PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice

letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

### ***Returned Provider Review Letter***

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that

have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

*Note:* When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

### ***Thirty Days to Respond to the Returned Provider Review Letter***

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status via WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

### ***Listing Procedure Codes Approved as a Group on the Decision Notice Letter***

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

### **New Amendment Process**

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information.

Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 5.

Attachment 6 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

### ***Returned Amendment Provider Review Letter***

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days, the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

*Note:* When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

## **Valid Diagnosis Codes Required**

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

## **Information Regarding Managed Care**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services (DHFS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHFS.

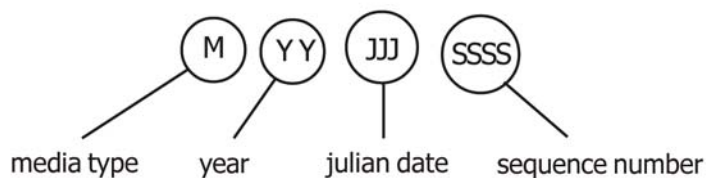
For questions, call Provider Services at (800) 947-9627 or visit our Web site at [dhfs.wisconsin.gov/forwardhealth/](http://dhfs.wisconsin.gov/forwardhealth/).

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# ATTACHMENT 1

## Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
<b>Media</b> — One digit indicates media type.	Digits are identified as follows: 1 = paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction
<b>Year</b> — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
<b>Julian date</b> — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
<b>Sequence number</b> — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

# **ATTACHMENT 2**

## **Prior Authorization Request Form (PA/RF)**

### **Completion Instructions for Substance Abuse Day Treatment Services**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), F-11037, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

#### **SECTION I — PROVIDER INFORMATION**

##### **Element 1 — HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP)**

Enter an “X” in the box next to HealthCheck “Other Services” if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck “Other Services.” Enter an “X” in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

##### **Element 2 — Process Type**

Enter process type “136” to indicate substance abuse day treatment services. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

##### **Element 3 — Telephone Number — Billing Provider**

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

##### **Element 4 — Name and Address — Billing Provider**

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

##### **Element 5a — Billing Provider Number**

Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

##### **Element 5b — Billing Provider Taxonomy Code**

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.



## SECTION II — MEMBER INFORMATION

### Element 6 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct number.

### Element 7 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

### Element 8 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

### Element 9 — Name — Member

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

### Element 10 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

## SECTION III — DIAGNOSIS / TREATMENT INFORMATION

### Element 11 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

### Element 12 — Start Date — SOI (not required)

### Element 13 — First Date of Treatment — SOI (not required)

### Element 14 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

### Element 15 — Requested PA Start Date

Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests. The maximum backdating allowed is five working days from the date of receipt at ForwardHealth.

### Element 16 — Rendering Provider Number (not required)

### Element 17 — Rendering Provider Taxonomy Code (not required)

### Element 18 — Procedure Code

Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) code for each service/procedure/item requested.

### Element 19 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed.

### Element 20 — POS

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed.

### Element 21 — Description of Service

Enter a written description corresponding to the appropriate HCPCS code for each service/procedure/item requested.

### Element 22 — QR

Enter the appropriate quantity (e.g., hours) requested for the procedure code listed.

**Element 23 — Charge**

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

**Element 24 — Total Charges**

Enter the anticipated total charges for this request.

**Element 25 — Signature — Requesting Provider**

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

**Element 26 — Date Signed**

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

# **ATTACHMENT 3**

## **Prior Authorization Request Form (PA/RF)**

### **(For Photocopying)**

(A copy of the "Prior Authorization Request Form [PA/RF]"  
is located on the following page.)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

1. Check only if applicable <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)	2. Process Type	3. Telephone Number — Billing Provider
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)		5a. Billing Provider Number
		5b. Billing Provider Taxonomy Code

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
9. Name — Member (Last, First, Middle Initial)         10. Gender — Member <input type="checkbox"/> Male <input type="checkbox"/> Female		

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date	

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

#### 26. Date Signed



# **ATTACHMENT 4**

## **Sample Prior Authorization Request Form (PA/RF) for Substance Abuse Day Treatment Services**

(The sample "Prior Authorization Request Form [PA/RF]" for substance abuse day treatment services is located on the following page.)

FORWARDHEALTH  
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)	2. Process Type <b>136</b>	3. Telephone Number — Billing Provider <b>(555) 555-5555</b>
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) <b>I.M. Provider</b> <b>1 W. Wilson</b> <b>Anytown WI 55555-5555</b>		5a. Billing Provider Number <b>0111111110</b>
		5b. Billing Provider Taxonomy Code <b>123456789X</b>

SECTION II — MEMBER INFORMATION

6. Member Identification Number <b>1234567890</b>	7. Date of Birth — Member <b>MM/DD/CCYY</b>	8. Address — Member (Street, City, State, ZIP Code) <b>555 Willow Rd</b> <b>Anytown WI 55555</b>
9. Name — Member (Last, First, Middle Initial) <b>Member, Im A</b>	10. Gender — Member <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description <b>303.90 — alcohol dependence</b>							12. Start Date — SOI		13. First Date of Treatment — SOI		
14. Diagnosis — Secondary Code and Description <b>305.20 — cannabis abuse</b>							15. Requested PA Start Date				
16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers				20. POS	21. Description of Service	22. QR	23. Charge	
		<b>H2012</b>	<b>HF</b>				<b>11</b>	<b>Behavioral health day treatment, per hour</b>	<b>64</b>	<b>XXX.XX</b>	

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. SIGNATURE — Requesting Provider <b>I.M. Provider</b>	26. Date Signed <b>MM/DD/CCYY</b>
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# **ATTACHMENT 5**

## **Prior Authorization Amendment Request Completion Instructions**

(A copy of the “Prior Authorization Amendment Request Completion Instructions”  
is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Original PA Number

Enter the unique PA number from the original PA to be amended.

#### Element 2 — Process Type

Enter the process type as indicated on the PA to be amended.

#### Element 3 — Member Identification Number

Enter the member ID as indicated on the PA to be amended.

#### Element 4 — Name — Member

Enter the name of the member as indicated on the PA to be amended.

### SECTION II — PROVIDER INFORMATION

#### Element 5 — Billing Provider Number

Enter the billing provider number as indicated on the PA to be amended.

#### Element 6 — Name — Billing Provider

Enter the name of the billing provider as indicated on the PA to be amended.

**SECTION III — AMENDMENT INFORMATION**

**Element 7 — Address — Billing Provider**

Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

**Element 8 — Requested Start Date**

Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

**Element 9 — Requested End Date (If Different from Expiration Date of Current PA)**

Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different than the current expiration date.

**Element 10 — Reasons for Amendment Request**

Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

**Element 11 — Description and Justification for Requested Change**

Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

**Element 12 — Are Attachments Included?**

Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

**Element 13 — Signature — Requesting Provider**

Enter the signature of the provider that requested the original PA.

**Element 14 — Date Signed — Requesting Provider**

Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

# **ATTACHMENT 6**

## **Prior Authorization Amendment Request (For Photocopying)**

(A copy of the "Prior Authorization Amendment Request"  
is located on the following page.)

**FORWARDHEALTH  
PRIOR AUTHORIZATION AMENDMENT REQUEST**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

**SECTION I — MEMBER INFORMATION**

1. Original PA Number	2. Process Type	3. Member Identification Number
4. Name — Member (Last, First, Middle Initial)		

**SECTION II — PROVIDER INFORMATION**

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

**SECTION III — AMENDMENT INFORMATION**

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)
10. Reasons for Amendment Request (Check All That Apply)	
<input type="checkbox"/> Change Billing Provider Number <input type="checkbox"/> Add Procedure Code / Modifier	
<input type="checkbox"/> Change Procedure Code / Modifier <input type="checkbox"/> Change Diagnosis Code	
<input type="checkbox"/> Change Grant or Expiration Date <input type="checkbox"/> Discontinue PA	
<input type="checkbox"/> Change Quantity <input type="checkbox"/> Other (Specify) _____	

11. Description and Justification for Requested Change

12. Are Attachments Included?    ☐ Yes    ☐ No  
If Yes, specify attachments below.

13. <b>SIGNATURE</b> — Requesting Provider	14. Date Signed — Requesting Provider
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# **ATTACHMENT 7**

## **Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions**

(A copy of the “Prior Authorization/Substance Abuse Day Treatment Attachment [PA/SADTA] Completion Instructions” is located on the following pages.)

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## FORWARDHEALTH PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory to receive PA for certain procedures/services/items. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA), F-11037, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member (Last, First, Middle Initial)

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Age — Member

Enter the age of the member in numerical form (e.g., 16, 21, 60).

#### Element 3 — Member Identification Number

Enter the Member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct Member ID.

### SECTION II — PROVIDER INFORMATION

#### Element 4 — Name and Credentials — Requesting / Rendering Provider

Enter the name and credentials of the therapist who will be providing treatment/service.

#### Element 5 — Telephone Number — Requesting / Rendering Provider

Enter the rendering provider's telephone number, including area code.

#### Element 6 — Name — Referring / Prescribing Provider

Enter the name of the provider referring/prescribing treatment.

#### Element 7 — Referring / Prescribing National Provider Identifier (NPI)

Enter the referring/prescribing National Provider Identifier (NPI).

The remaining portions of this attachment are to be used to document the justification for the service requested. **Substance abuse day treatment is not a covered service for members who are residents of a nursing home or who are hospital inpatients.**

### SECTION III — DOCUMENTATION

#### Element 8

Describe the length and intensity of treatment requested. Include the anticipated beginning treatment date and estimated substance abuse day treatment discharge date, and attach a copy of treatment design.

#### Element 9

List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

#### Element 10

List the codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for the member's current primary and secondary diagnosis. Allowable DSM diagnoses are 303.90 (alcohol dependence), 304.00-304.90 (drug dependence), 305.00 (alcohol abuse), or 305.20-305.90 (other drug abuse, excluding caffeine intoxication).

#### Element 11

Describe the member's current clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.)

#### Element 12

Indicate whether or not the member has received any substance abuse treatment in the past 12 months. If the member has received substance abuse day treatment within the past 12 months, indicate the date for each treatment episode, the type of service provided, and the treatment outcomes.

#### Element 13

If the member received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past 12 months, give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

#### Element 14

Describe the member's severity of illness using the indicators in a-f. Refer to the substance abuse day treatment criteria on the Substance Abuse Day Treatment page of the Online Handbook.

#### Element 15

Describe the member's treatment plan and attach a copy of the plan.

#### Element 16 — Signature — Member or Representative

Signature of the member or representative indicates the signer has read the attached request for PA of substance abuse and agrees that it will be sent to ForwardHealth for review.

#### Element 17 — Date Signed

Enter the month, day, and year the PA/SADTA was signed by the member or the member's representative (in MM/DD/CCYY format).

#### Element 18 — Relationship (if representative)

Include relationship to member (if a representative signs).

#### Element 19 — Signature — Rendering Provider

Enter the signature of the rendering provider.

#### Element 20 — Date Signed

Enter the month, day, and year the PA/SADTA was signed by the rendering provider (in MM/DD/CCYY format).

#### Element 21 — Discipline of Rendering Provider

Enter the discipline of the rendering provider.

#### Element 22 — Signature — Supervising Physician or Psychologist

Enter the signature of the supervising physician or psychologist.

#### Element 23 — Date Signed

Enter the month, day, and year the PA/SADTA was signed by the supervising physician or psychologist (in MM/DD/CCYY format).

#### Element 24 — Supervising Physician or Psychologist's NPI

Enter the supervising physician or psychologist's NPI.



# **ATTACHMENT 8**

## **Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) (For Photocopying)**

(A copy of the "Prior Authorization/Substance Abuse Day Treatment Attachment [PA/SADTA]" is located on the following pages.)

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**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)**

Providers may submit prior authorization (PA) requests to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions, F-11037A.

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**SECTION I — MEMBER INFORMATION**

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1. Name — Member (Last, First, Middle Initial)

2. Age — Member

3. Member Identification Number

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**SECTION II — PROVIDER INFORMATION**

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4. Name and Credentials — Requesting / Rendering Provider

5. Telephone Number — Requesting / Rendering Provider

6. Name — Referring / Prescribing Provider

7. Referring / Prescribing National Provider Identifier (NPI)

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**SECTION III — DOCUMENTATION**

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8. Describe length and intensity of treatment requested.

- Program request is for \_\_\_\_\_ hours per day,  
\_\_\_\_\_ days per week,  
for \_\_\_\_\_ weeks,  
for a total of \_\_\_\_\_ hours.
- Anticipated beginning treatment date \_\_\_\_\_.
- Estimated substance abuse day treatment discharge date \_\_\_\_\_.
- Attach a copy of treatment design, which includes the following:
  - a. A schedule of treatment (day, time of day, length of session, and service to be provided during that time).
  - b. A brief description of aftercare / continuing care / follow-up component (also include this information in the treatment plan section of this form).

9. List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

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*Continued*



DT-PA051-051

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**SECTION III — DOCUMENTATION (Continued)**

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10. List the **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* for the member's current primary and secondary diagnosis.

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11. Describe the member's **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.)

- 
12. Has the member received any substance abuse treatment in the past 12 months? ☐ Yes ☐ No  
If "Yes," provide information on the date of each treatment episode, the type of service provided, and the **treatment outcomes**.

- 
13. Has the member received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past 12 months? ☐ Yes ☐ No  
If "Yes," give rationale for appropriateness and medical necessity of the current request. Describe projected outcome of additional treatment requested.

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**SECTION III — DOCUMENTATION (Continued)**

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14. Describe the member's severity of illness using the following indicators. Individualize all information.

- a. Loss of control / relapse crisis.
- b. Physical conditions or complications.
- c. Psychiatric conditions or complications. (Include psychiatric diagnosis, medications, current psychiatric symptoms.)
- d. Recovery environment.
- e. Life areas impairment. (Specify social / occupational / legal / primary support group.)
- f. Treatment acceptance / resistance.

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15. Treatment Plan

- **Attach** a copy of the member's substance abuse day treatment plan (refer to intensity of service guideline in the substance abuse day treatment criteria).
- Describe any special needs of the member and indicate how these will be addressed (for example, educational needs, access to treatment facility).
- Describe the member's family / personal support system. Indicate how these issues will be addressed in treatment, if applicable. If family members / personal support system are not involved in treatment, explain why not.

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*Continued*

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**SECTION III — DOCUMENTATION (Continued)**

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**15. Treatment Plan (Continued)**

- Briefly describe treatment goals and objectives in specific and measurable terms.
  
  
  
  
  
  
  
  
  
  
- Describe the expected outcomes of treatment including the plan for continuing care.

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I have read the attached request for PA of substance abuse day treatment services and agree that it will be sent to ForwardHealth for review.

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**16. SIGNATURE** — Member or Representative

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**17. Date Signed**

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**18. Relationship (if representative)**

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Attach a photocopy of the physician's current prescription for substance abuse day treatment. (Must be dated within one month of receipt at ForwardHealth.)

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**19. SIGNATURE** — Rendering Provider

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**20. Date Signed**

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**21. Discipline of Rendering Provider**

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**22. SIGNATURE** — Supervising Physician or Psychologist

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**23. Date Signed**

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**24. Supervising Physician or Psychologist's NPI**

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